FREDERICK Medical & Pulmonary ASSOCIATES

NEIL V. WARAVDEKAR, M.D. • MICHAEL A. TOLINO, M.D.
ANISH S. DESAI, M.D. • PHUONG D. HO, M.D.
PULMONARY & CRITICAL CARE MEDICINE

Please complete this form to help us for your upcoming visit in our office. We need this **BEFORE** your visit.

NAME: _____ DOB: _____

WHY ARE YOU COMING TO SEE US? _____

PLEASE LIST YOUR CURRENT DOCTORS AND PHONE NUMBERS:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

CURRENT MEDICAL CONDITIONS:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PAST SURGERIES: (PLEASE INCLUDE APPROXIMATE DATE AND TYPE OF SURGERY:

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

FATHER: ALIVE or DECEASED CAUSE OF DEATH: _____

MEDICAL PROBLEMS: _____

MOTHER: ALIVE or DECEASED CAUSE OF DEATH: _____

MEDICAL PROBLEMS: _____

DO ANY OF THESE LUNG DISEASES RUN IN YOUR FAMILY? (CIRCLE)

ASTHMA COPD/EMPHSYEMA/CHRONIC BRONCHITIS LUNG CANCER

PULMONARY FIBROSIS TB/TUBERCULOSIS

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SOCIAL HISTORY

DID YOU EVER WORK OUTSIDE THE HOME? YES NO RETIRED HOMEMAKER

JOBS: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPERATED

DID YOU EVER SMOKE? YES NO HOW MANY PACKS PER DAY? _____

HOW MANY YEARS? _____ DO YOU STILL SMOKE? YES NO

DO YOU VAPE? YES NO

DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____

HOW OFTEN? _____

MEDICATION ALLERGIES:

DRUG AND REACTION: _____

MEDICATION INFORMATION

CURRENT MEDICATONS:

NAME	STRENGTH	HOW MANY TIMES A DAY

PLEASE USE ADDITIONAL SHEET OF PAPER IF NECESSARY

DATES OF VACCINES: PNEUMONIA VACCINE: _____ WAS IT PREVNAR 13? YES NO

FLU VACCINE: _____

COVID: VACCINE: _____ BOOSTER? YES NO

7115 Guilford Drive, Suite 202 • Frederick, Maryland 21704 • p: 301-663-5922 f: 301-663-8292

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered the notice of Privacy Practices from Frederick Medical and Pulmonary Associates, PA.

_____ _____
Signature Date

Please list up to two individuals with whom we may discuss information regarding your care at Frederick Medical and Pulmonary Associates, PA.

1._____ _____ _____
NAME RELATIONSHIP TELEPHONE NUMBER

2._____ _____ _____
NAME RELATIONSHIP TELEPHONE NUMBER

OR:

_____I do not want you to discuss information regarding my care with anyone other than myself.

_____ _____
Signature Date

We have chosen to participate in the Chesapeake Regional Information Systems for our Patients, Inc. (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public Health Reporting and Controlled Dangerous Substances Information. as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

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FINANCIAL POLICY

Please read the following agreement and then sign and date this form to show that you have read and understand this policy. It explains your financial obligations while under our care and our office policies.

CANCELLATION:

We realize that a situation may arise that could force you to postpone your visit. Please understand that such changes affect not only our DOCTORS and our staff, but other patients as well.

If you cancel your appointment with less than a 24 hours' notice, or fail to show for your appointment without notification, you will be charged a service fee up to but, not to exceed $50.00 for any missed Office Visit and/or $150.00 for a missed Consultation Appointment.

If you cancel your testing appointment with less than 24 hours' notice or fail to show for your testing appointment without notification, the following fees apply: $25.00 for Pulmonary Function Test and $250.00 for a Polysomnogram (Sleep Study).

The applicable missed fee must be collected before you reschedule your appointment.

RETURNED CHECKS

Any checks returned from your bank unpaid, will be assessed a fee of $30. After a returned check is received, we will no longer accept checks from you.

INSURANCE INFORMATION

We bill most insurance carriers for you, if proper paperwork is provided for us. Co-payments are due at the time of service. **It is your responsibility to know what your benefits and copays are through your insurance carrier.**

Self-pay patients must make payment, in full, at the time the service is provided.

Non covered services must be paid in full at the time services are provided.

MEDICAL RECORDS

There is a fee for any medical records copied. The fees are as follows: 76 cents per page copying fee plus the cost of postage if we are mailing the records to the patient. A medical records release form must be signed first.

A charge for form completion of $25.00 is required for any forms needed to be completed by our physicians. Your insurance carrier does not cover this charge. The patient must schedule and office visit and bring the form to the office visit. Payment is expected at the time of completion.

COLLECTIONS

Payment is due at time of service. Aging on accounts begins as of the date of service. Billing arrangements must be approved by the billing staff.

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After 90 days an unpaid account will be referred to collections.
Collections will have two phases. Initial phase will consist of letter/phone contact. Patient's balances will not be written off. Patients may also be assessed a collections fee which is based on the amount that is unpaid by the patient. Phase two begins after 90 days if no payments are being made on the account. The patient agrees to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt, and all costs, and expenses, including reasonable attorney fees, we incur in such collection efforts. These accounts will be considered in default. The patient will be discharged and not allowed to return to the practice.
Patients with a balance, who provide us an incorrect address and/or invalid telephone number, may be referred to Phase 2 collections without notice. Also those patients who do not provide us with a change of address/phone number within 30 days of the change may also be referred to collections without notice.

MEDICARE PATIENTS

Please read and sign below. I request payment of authorized Medicare benefits be made either to me or my behalf to Frederick Medical and Pulmonary Associates for any services furnished to me by the listed facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determined of the Medicare carrier as the full charge and the patient is responsible only for the co-insurance, deductible and non-covered services. Co-insurances and the deductible are based upon the charge determination of the Medicare carrier.

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Frederick Medical & Pulmonary Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Frederick Medical & Pulmonary Associates to release all information necessary to secure the payment.

I have read, understand, and agree to the financial policy. I hereby authorize the release of any pertinent information to your insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay all collection fees, court costs, and attorney fees. I, also, authorize agents to communicate via cell phone to address my issues related to service and/or in facilitating payment. I/the patient understand this is authorizing and/or their agents to communicate by means of an automated computerized dialer, and I understand that this form of communication may incur an expense per minute. I understand that ultimately the patient is responsible for all facility fees. I also understand that this agreement can be changed by Frederick Medical & Pulmonary Associates without further notice to the patient.

_____ _____
Patient's Name (please print) Date

_____
Signature of Patient and/or Guardian